Second victims of medical errors and incidents

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Overview

- Organisational case history
- Definitions
- Prevalence and effects
- Approaches which may help
- Further work

Sources;
Jim Conway, SVP, Institute for Healthcare Improvement, Boston, USA
MITSS (Medically Induced Trauma Support Services, Boston USA
Reema Sirriyeh, Bradford Institute for Health Research, UK

….by 4pm, Christmas Eve

- 2 previously healthy new mothers who had delivered in our Maternity Unit in the last 48 hours had died;
  - One (apparently) from Group A Streptococcus (GAS) infection
  - The second not obviously related at this stage but……???

Context

- Maternity Unit 2,500 deliveries annually
  - Above average ratings, well-regarded locally
  - The last maternal death had been in 1996
- There was a recent increase in GAS infection locally
- (In the UK, from 2006 to 2008 there were 13 maternal deaths linked to GAS)

Context 2

- An organization in transition
  - New CEO, first post
  - New Chairman
  - Several Board and executive team vacancies, interims etc
- Christmas Holidays

My immediate concerns

- Could this really be as bad as it seems?
  - How could the cases be linked?
  - Could there be ongoing risk to others?
  - Are staff implicated?
  - What do we do now?
- Are there existing mechanisms for dealing with this sort of thing?

Subsequently….

- Both deaths due to GAS
- No further deaths but several contacts became ill
- Independent inquiry
- Coroner's investigations
- Publicity +++, newspapers, TV etc

Inquests May 2009

- No route of transmission established
- We were found to have made mistakes and have deficiencies in systems, but to have done everything which could reasonably be expected to investigate
- We were commended for our approach to the investigation by the Coroner and the families' legal teams
- The media gave us reasonable reports
- We published the investigation report on the internet

(http://www.wehct.nhs.uk/index/ournews.htm?newsid=9231)

What went well*

- Assuming the worst
- Taking control early and being decisive
- Being seen
- Managing other senior leaders
- The ad hoc crisis team

…considering the tragic circumstances for 2 families

What went well

- Being open
- Patient and family support
- A proactive media strategy
- Media training
- The independent review

What could have been better

- Having a plan
- Our capacity to respond was very stretched due to;
  - An inexperienced leadership team in transition
  - Christmas holidays
- Staff support

Staff

- I didn’t adequately recognise the trauma for staff at all levels;
  - Frontline
  - Senior clinical leaders
  - Organisational leaders
- This was aggravated by the investigation and external publicity

Staff support

- I had experienced the “second victim” role before..
- …but was not really aware of systematic work in this area
- For me, it felt very personal (which probably impaired my ability to recognise and respond to others)

Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.[1–8]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,[4] reassurance from colleagues is often grudging or qualified. One

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117748/pdf/726.pdf

BMJ VOLUME 320 18 MARCH 2000

IHI experience

- IHI regularly get asked to help organisations across the US facing similar crises
- A framework for response has been developed drawn from this experience and from the business literature
- IHI works closely with MITSS, a support group for both patients and clinicians

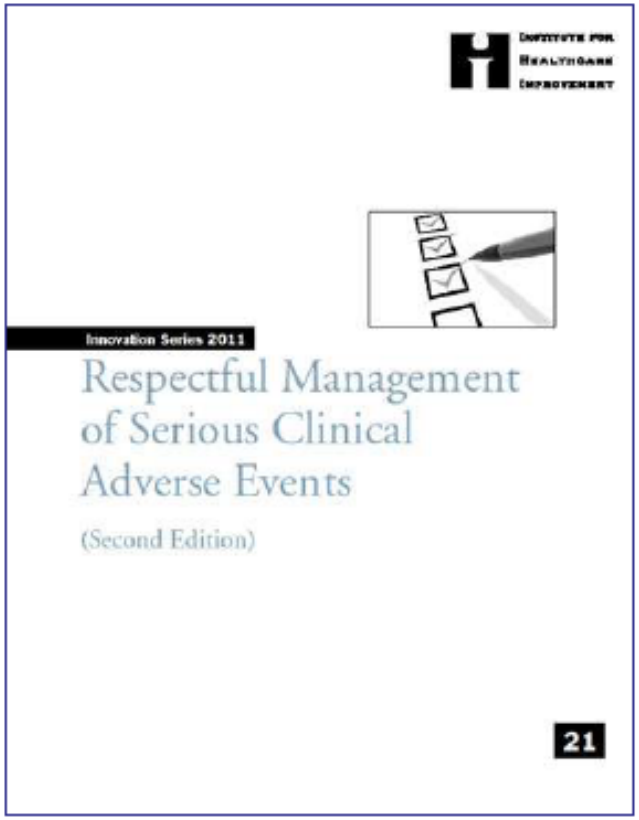
IHI experience

- Most organisations;
  - Don’t plan
  - Regard each crisis as unique
  - Make matters worse by their response
  - Don’t learn

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Respectful Management of Serious Clinical Adverse Events

What's Your Crisis Management Plan?



Key elements of clinical crisis management

- Advance planning;
  - 75% of required actions are predictable
- Priorities;
  1. Patients and families
  2. Staff
  3. The Organisation

Second Victim Definition

- A health care provider involved in an unanticipated adverse event or a medical error who is traumatized by the event
- Healthcare provider who is involved with a patient adverse event who subsequently has difficulty coping with emotions

Albert Wu, The Emergence of Second Victim and Clinician Support Programs, MITSS, 2011, Boston.

Second victim effects

- Acute stress reactions (days to weeks)
  - ***Numbness, anxiety, sleep disturbance, grief, detachment, loss of trust, lack of concentration, poor memory***
- Longer term effects
  - ***Shame, guilt, anger, self-doubt, flashbacks, irritability (similar to PTSD?), depression, behavioural change, drug and alcohol abuse etc***

Severity related to…

- The severity of the incident
- The characteristics of the patient
- The attitude of clinical colleagues
- The conduct of the enquiry
- Legal proceedings
- (Inversely) the relationship with the patient

Prevalence

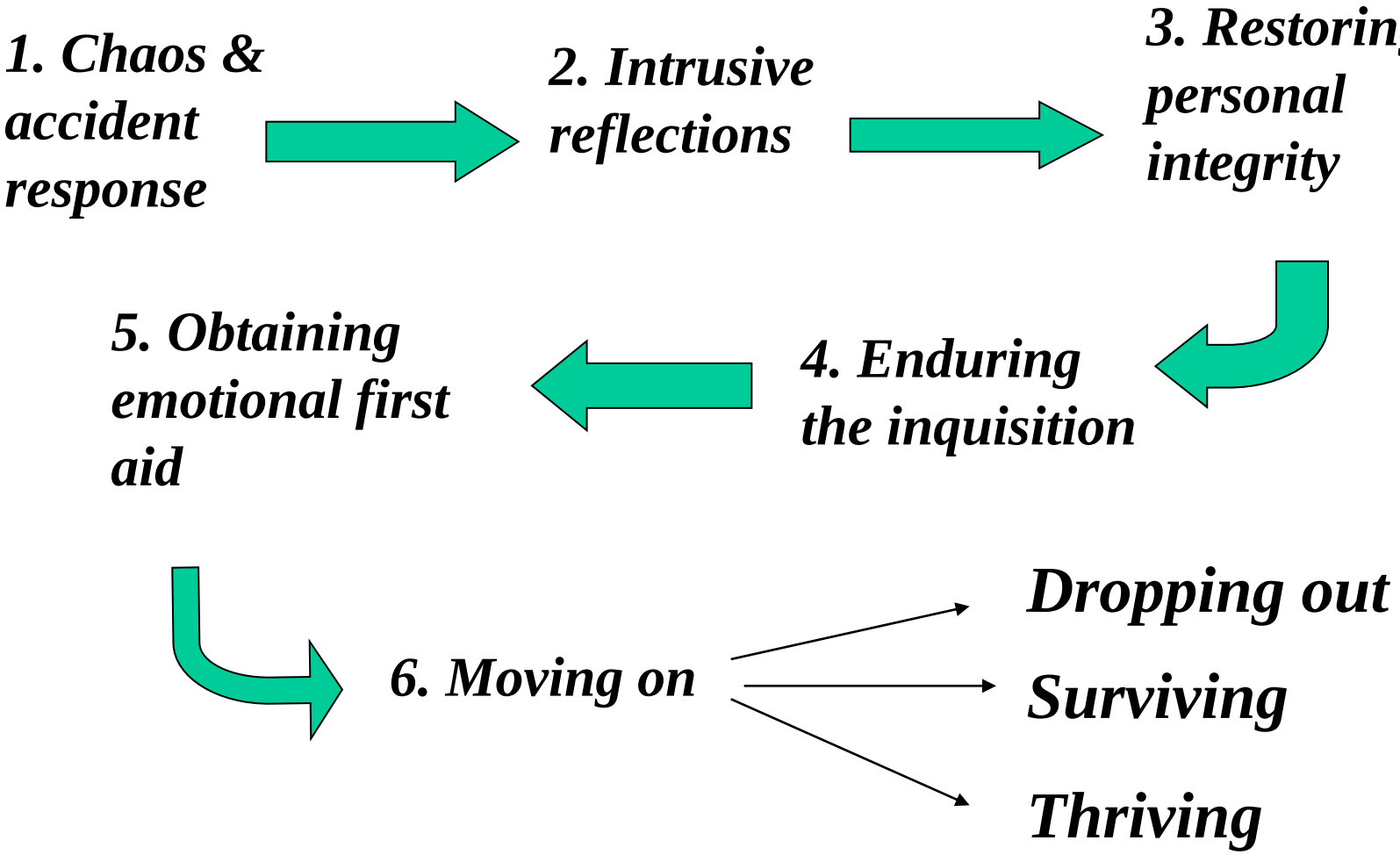
- Estimates between 7 and 40% of medical incidents, depending on;
  - Severity of incident
  - Organisational responses
  - Support mechanisms
  - Professional and organisational culture
  - Willingness of individuals to report

Consequences

- Patient safety risks
  - Immediate aftermath
  - Longer term consequences for safety culture, openness, team-working, defensive practice, disruptive behaviour, working relationships etc
- Staff health, welfare, recruitment & retention
- Education and training risks

Trajectory of recovery

(Scott 2009)



What can we do?

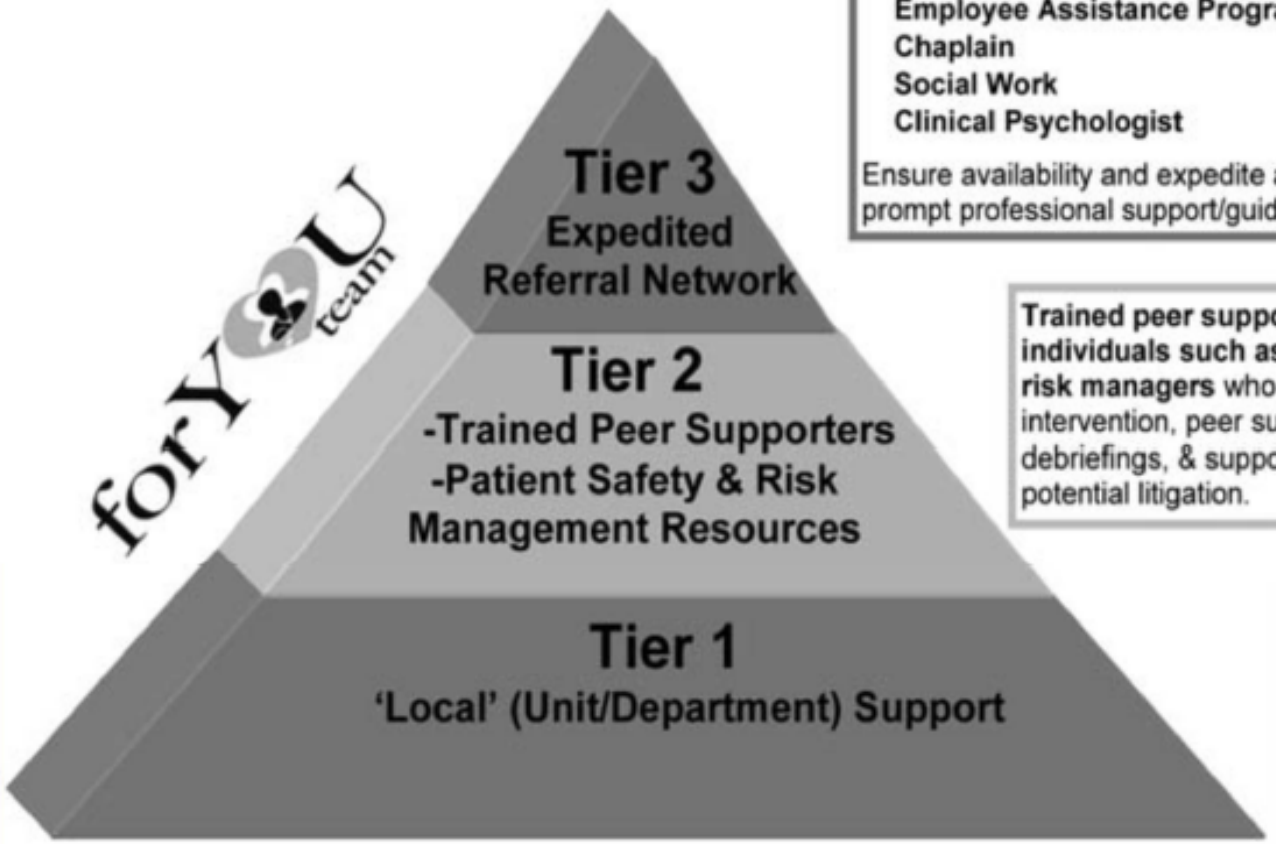
- As leaders and professional bodies
- As organisations
- As individuals
  - The second victim
  - Colleagues of second victims

As leaders and professional bodies

- Recognise and publicise the concept, and that….
  - it's primarily a patient safety issue
  - something can be done
- Promote work to understand the best approaches to support within a wider culture of openness and learning from mistakes
- Model expected behaviours

As organisations

- Build structures into incident responses to;
  - Recognise and mitigate the potential risks to patients after an incident
  - Recognise and support second victims
- Promote and model a (genuinely) open, transparent, non-judgemental reporting culture



Established Referral Network with
- **Employee Assistance Program**
- **Chaplain**
- **Social Work**
- **Clinical Psychologist**

Ensure availability and expedite access to prompt professional support/guidance.

Trained peer supporters and support individuals such as patient safety officers or risk managers who provide one on one crisis intervention, peer supporter mentoring, team debriefings, & support through investigation and potential litigation.

Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.

Scott S. et.al. Caring for Our Own: Deploying a Systemwide Second Victim Rapid Response Team. Jt Comm J Qual Patient Saf. 2010, 36(5)

As individuals

- Colleagues
  - Offer informal support to colleagues who may be potential second victims
  - Recognise effects in yourself and seek help early

RCP work

- Second Victim work as part of our Patient Safety agenda
- With the Bradford Institute for Health Research
  - European meeting in Bradford Nov 13/4 to share experiences
  - Planned survey of RCP Fellows and Members in early 2013

Summary

- Second victim effects are common
- This is;
  - Dangerous for patients
  - Harmful for clinicians
  - Bad for the service
- Something can be done to reduce these risks

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Useful references

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